PERMISSION TO RELEASE LEARNING DISABILITIES INFORMATION

PARTICIPANT'S NAME	SOCIAL SECURITY NUMBER

I understand that I do not have to let others know about a disability that I may have, and I can volunteer this information whenever I want.

Check the boxes for which the participant voluntarily gives his/her permission:

☐ RELEASE OF INFORMATION TO COUNTY WELFARE DEPARTMENT

(Place copy in the case file; send original to the Provider/Source)

I give permission for the ______________________ County Welfare Department to receive
NAME OF COUNTY
a copy of any screening, evaluation, diagnosis, and/or accommodations information on me about possible learning disabilities. This information can only be used to develop or change my Welfare-to-Work plan and/or to see what accommodations and services I may need to participate in an education, job training, work activity, and/or other Welfare-to-Work activity. The county will not tell any employer about my disability without my separate written permission.

☐ RELEASE OF INFORMATION FROM COUNTY WELFARE DEPARTMENT

(Place original in the case file)

I give permission for the ______________________ County Welfare Department to
NAME OF COUNTY
release screening, evaluation, diagnosis, and/or accommodations information about learning disabilities I may have. This information can only be used to develop or change my Welfare-to-Work plan and/or determine helpful accommodations and services I may need in educational, job training, or work settings.

The County Welfare Department may release the information to (*check all that apply)*:

☐ ______________________, who will be testing me for possible learning disabilities
NAME OF LEARNING DISABILITIES EVALUATOR

☐ New County Welfare Department if I move to another county

☐ State and/or local employment training and/or job training agencies that are noted below *(check all that apply)*:

- ☐ Employment Development Department
- ☐ Local Workforce Investment Area Agency
- ☐ Local One-Stop Center
- ☐ Department of Rehabilitation

☐ Local, state, or private college *(specify)*:______________________

☐ Other *(specify)*:______________________

PARTICIPANT'S SIGNATURE

I understand that:

- If I refuse to complete and sign this form and move out of the county, a copy of any screening, evaluation, diagnosis, and/or accommodations information on me about possible learning disabilities will not be sent to the new county. My Welfare-to-Work plan in the new county may not include accommodations for my learning disabilities provided in this county.
- This information is needed to comply with Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and Welfare and Institutions Code Section 11325.4.
- This information will be kept confidential in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law.
- This permission form, except for action already taken, may be canceled by me at any time. If I do not cancel this form, it will end one year from the date of my signature.

I have read this form (or had it read to me) after it was completed and before I signed it. I know I can get a copy of this form if I ask for it.

PARTICIPANT'S SIGNATURE	TODAY'S DATE